***State:*** *Arkansas* ***Filing Company:*** *Royal Neighbors of America*
***TOI/Sub-TOI:*** *L08 Life - Other/L08.000 Life - Other*
***Product Name:*** *Applications*
***Project Name/Number:*** *1725/1725*

## Filing at a Glance

| | |
|---|---|
| Company: | Royal Neighbors of America |
| Product Name: | Applications |
| State: | Arkansas |
| TOI: | L08 Life - Other |
| Sub-TOI: | L08.000 Life - Other |
| Filing Type: | Form |
| Date Submitted: | 10/15/2012 |
| SERFF Tr Num: | RNOA-128727993 |
| SERFF Status: | Closed-Approved-Closed |
| State Tr Num: | |
| State Status: | Approved-Closed |
| Co Tr Num: | 1725 RNOA-128727993 |
| Implementation Date Requested: | On Approval |
| Author(s): | John Friederich, Philip Blankenfeld, Deb Zemo |
| Reviewer(s): | Linda Bird (primary) |
| Disposition Date: | 10/17/2012 |
| Disposition Status: | Approved-Closed |
| Implementation Date: | |

State Filing Description:

**State:** *Arkansas* **Filing Company:** *Royal Neighbors of America*
**TOI/Sub-TOI:** *L08 Life - Other/L08.000 Life - Other*
**Product Name:** *Applications*
**Project Name/Number:** *1725/1725*

## General Information

Project Name: 1725
Project Number: 1725
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Deb Zemo

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Illinois has been submitted under the IIPRC
Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/17/2012
State Status Changed: 10/17/2012
Created By: Deb Zemo
Corresponding Filing Tracking Number: 1725

Filing Description:

PLEASE NOTE, the main reason for this filing is to update the Society's current applications to include correct MIB data prior to January 1, 2013, as required.

The application forms are intended to replace applications that were approved by your office for use in your state on the dates noted in the Supporting Documentation tab.

Except for the form number, revision date, and addition of the MIB data, the only other differences between the original applications are the STOLI questions included in form series 1725.

Form 1725 Rev. 10-2012 Application for Term Insurance
• The Authorization was amended by adding the following sentence to comply with MIB language requirements: "I further authorize RNA, or its reinsurers, to make a brief report of my personal health information to MIB."
• The MIB, Inc., Notice was amended by updating the mailing address for MIB: "50 Braintree Hill Park, Suite 400, Braintree, MA 02184."
• Three questions (numbered 9; 10; and 11) were added to Section 7 – General Risk Questions located on Page 2 of the application to comply with STOLI requirements.

Form 101720 Rev. 10-2012 Application for Simplified Issue Individual Whole Life Insurance
• The Authorization was amended by adding the following sentence to comply with MIB language requirements: "I further authorize RNA, or its reinsurers, to make a brief report of my personal health information to MIB."
• The MIB, Inc., Notice was amended by updating the mailing address for MIB: "50 Braintree Hill Park, Suite 400, Braintree, MA 02184."

Form 111722-AR Rev 10-2012 Application for Single Premium Individual Whole Life Insurance
• The Authorization was amended by adding the following sentence to comply with MIB language requirements: "I further authorize RNA, or its reinsurers, to make a brief report of my personal health information to MIB."
• The MIB, Inc., Notice was amended by updating the mailing address for MIB: "50 Braintree Hill Park, Suite 400, Braintree, MA 02184."

To the best of my knowledge and belief, no part of this submission contains any unusual or controversial items contrary to normal industry standards, and no assumptions or provisions contained in the application unfairly discriminate in the availability of rates or benefits for applicants of the same class, equal expectation of life, or degree of risk or hazard.

***State:*** *Arkansas* ***Filing Company:*** *Royal Neighbors of America*
***TOI/Sub-TOI:*** *L08 Life - Other/L08.000 Life - Other*
***Product Name:*** *Applications*
***Project Name/Number:*** *1725/1725*

Form numbers, descriptions, and approval dates of the forms being replaced are included in the Supporting Documentation tab.

## Company and Contact

### Filing Contact Information

Debra Zemo, Compliance Assistant/Legal Secretary
zemodm@royalneighbors.org
230 16th Street
800-627-4762 [Phone] 8233 [Ext]
Rock Island, IL 61201
309-788-3887 [FAX]

### Filing Company Information

Royal Neighbors of America
230 16th Street
Rock Island, IL 61201
(309) 732-8232 ext. 8232[Phone]

CoCode: 57657
Group Code:
Group Name: Royal Neighbors
FEIN Number: 36-1711198

State of Domicile: Illinois
Company Type: Life, Health, Annuity
State ID Number:

## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $150.00 |
| Retaliatory? | No |
| Fee Explanation: | 3 forms x $50 + $150 |
| Per Company: | No |

| Company | Amount | Date Processed | Transaction # |
|---|---|---|---|
| Royal Neighbors of America | $150.00 | 10/15/2012 | 63889910 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *RNOA-128727993* | ***State Tracking #:*** | | ***Company Tracking #:*** | *1725 RNOA-128727993* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Royal Neighbors of America* |
| ***TOI/Sub-TOI:*** | *L08 Life - Other/L08.000 Life - Other* | | |
| ***Product Name:*** | *Applications* | | |
| ***Project Name/Number:*** | *1725/1725* | | |

# Correspondence Summary

## Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Linda Bird | 10/17/2012 | 10/17/2012 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *RNOA-128727993* | ***State Tracking #:*** | | ***Company Tracking #:*** | *1725 RNOA-128727993* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Royal Neighbors of America* |
| ***TOI/Sub-TOI:*** | *L08 Life - Other/L08.000 Life - Other* | | |
| ***Product Name:*** | *Applications* | | |
| ***Project Name/Number:*** | *1725/1725* | | |

## Disposition

Disposition Date: 10/17/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | | Yes |
| **Supporting Document** | Application | | No |
| **Supporting Document** | Applications replaced: | | Yes |
| **Form** | Application for Term Life Insurance | | Yes |
| **Form** | Application for Simplified Issue Individual Whole Life Insurance | | Yes |
| **Form** | Application for Single Premium Whole Life Insurance | | Yes |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *RNOA-128727993* | ***State Tracking #:*** | | ***Company Tracking #:*** | *1725 RNOA-128727993* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Royal Neighbors of America* |
| ***TOI/Sub-TOI:*** | *L08 Life - Other/L08.000 Life - Other* | | |
| ***Product Name:*** | *Applications* | | |
| ***Project Name/Number:*** | *1725/1725* | | |

# Form Schedule

**Lead Form Number: 1725**

| Item No. | Schedule Item Status | Form Number | Form Type | Form Name | Action/ Action Specific Data | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|
| 1 | | 1725 Rev. 10-2012 | AEF | Application for Term Life Insurance | Initial: | | 1725.pdf |
| 2 | | 101720 Rev. 10-2012 | AEF | Application for Simplified Issue Individual Whole Life Insurance | Initial: | | 101720 SIWL.pdf |
| 3 | | 111722-AR Rev. 10-2012 | AEF | Application for Single Premium Whole Life Insurance | Initial: | | 111722-AR.pdf |

**Form Type Legend:**

| | | | |
|---|---|---|---|
| **ADV** | Advertising | **AEF** | Application/Enrollment Form |
| **CER** | Certificate | **CERA** | Certificate Amendment, Insert Page, Endorsement or Rider |
| **DDP** | Data/Declaration Pages | **FND** | Funding Agreement (Annuity, Individual and Group) |
| **MTX** | Matrix | **NOC** | Notice of Coverage |
| **OTH** | Other | **OUT** | Outline of Coverage |
| **PJK** | Policy Jacket | **POL** | Policy/Contract/Fraternal Certificate |
| **POLA** | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | **SCH** | Schedule Pages |

INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES℠

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# Application for Term Insurance

## PART 1

## SECTION 1 – Proposed Insured

Name _____ Street _____

City _____ State_____ ZIP_____ Years at this address*_____

SSN/Tax ID _____ *If less than 3 yrs., add prior residence address in additional info, pg 4.

Phone number (  ) _____ Marital status ❑ S ❑ M ❑ W ❑ D Sex ❑ M ❑ F

❑ U.S. driver's license ❑ Green Card ❑ Passport DOB_____ State/Country of birth _____

❑ Other_____ Annual income $_____

ID number_____ ID issuer _____ Employer's name _____

ID issue date_____ ID expiration date_____ Position/Title_____

E-mail address_____ Duties_____ Length of employment_____

Are you a U.S. citizen? ❑ Yes ❑ No If No, are you a legal U.S. resident? ❑ Yes ❑ No

Do you wish to designate another person (secondary addressee) to receive copies of any premium lapse notices? ❑ Yes ❑ No

Name_____ Address_____Phone (____)_____

## SECTION 2 – Other Insurance

**1. EXISTING or APPLIED FOR INSURANCE**

Does the Proposed Insured have any existing or applied for life insurance (L) or annuity (A) contracts with this or any other company? ❑ Yes ❑ No

**IF YES,** complete and submit state replacement forms, if required, with this application.

Provide details:

| Company | Type (L, A) | Amount of Insurance | Year of Issue | Accidental Death Amount | Existing or Applied for |
|---|---|---|---|---|---|
| | | | | | ❑ E ❑ A |
| | | | | | ❑ E ❑ A |

**2. REPLACEMENT**

In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? ❑ Yes ❑ No

**If Yes,** complete and submit a replacement questionnaire **AND** any other state required replacement forms with this application.

## SECTION 3 – Ownership (Complete if Owner is other than Proposed Insured)

**1. OWNER other than PROPOSED INSURED**

Name _____ SSN/Tax ID_____

Street _____ Phone number (  )_____ DOB_____

City_____ State_____ ZIP_____ Relationship to Proposed Insured_____

❑ U.S. driver's license ❑ Green Card ❑ Passport E-mail address _____

❑ Other_____

ID number_____ ID issuer_____

ID issue date_____ ID expiration date_____

❑ Check if you wish ownership to revert to Insured upon Owner's death.

There may be tax consequences, please consult your tax advisor.

*If you need more space, please use the additional information section on page 4.*

## SECTION 4 – Beneficiary(ies)

Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.

**❑ PRIMARY**

Name _____

Street _____

City _____ State _____ ZIP _____

DOB _____ SSN/Tax ID _____

Relationship to Proposed Insured _____

Percent of proceeds _____%

**❑ PRIMARY ❑ CONTINGENT**

Name _____

Street _____

City _____ State _____ ZIP _____

DOB _____ SSN/Tax ID _____

Relationship to Proposed Insured _____

Percent of proceeds _____%

## SECTION 5 – Information Regarding Insurance Applied for

**1. PRODUCT & FACE AMOUNT**

Product name _____ Plan ❑ 10-yr. ❑ 20-yr. ❑ 30-yr. ❑ Other _____

Face amount $_____ OR Income Replacement Benefit Payment Amount $_____ # of payments _____

Number of months for initial lump sum _____ (1-6 months)

Riders/Benefits: ❑ Accelerated Death Benefit ❑ Premium Waiver Disability ❑ Return of Premium ❑ Other _____

## SECTION 6 – Payment Information

If **Electronic Payment** is chosen, complete Pre-Authorized Collection (PAC) form on page 7.

**1. PAYMENT MODE** *(Check one)*

Direct bill: ❑ Annual ❑ Semi-Annual ❑ Quarterly

Electronic payment: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly

❑ Payment with app $_____ ❑ Draft first payment

Additional details _____

**2. BILLING ADDRESS INFORMATION**

❑ Proposed Insured's address ❑ Primary Owner's address

❑ Other Premium Payor's/Alternate billing address *(details below)*

Name _____

Street _____

City _____ State _____ ZIP _____

❑ Special arrangements _____

## SECTION 7 – General Risk Questions

Has the Proposed Insured:

| | | |
|---|---|---|
| **1.** In the past 5 years, done any flying other than as an airline passenger or engaged in vehicle racing, underwater diving, or sky diving? | ❑ Yes | ❑ No |
| **2.** Any current or expected duties with the Armed Forces? | ❑ Yes | ❑ No |
| **3.** In the past 3 years, used tobacco products? If Yes, identify what was used, how much, and dates of usage. | ❑ Yes | ❑ No |
| **4.** In the past 3 years, been convicted of one or more vehicle moving violations, driving under the influence of alcohol or drugs, or ever had a driver's license revoked or suspended? | ❑ Yes | ❑ No |
| **5.** Ever had an application for life or health insurance declined, postponed, up-rated or modified, or any insurance cancelled or its renewal refused? | ❑ Yes | ❑ No |
| **6.** Ever claimed disability benefits for an injury, illness, or impaired condition? | ❑ Yes | ❑ No |
| **7.** Been convicted of a felony? | ❑ Yes | ❑ No |
| **8.** Any plans to travel or reside outside the U.S.? | ❑ Yes | ❑ No |

**Has the Proposed Insured or Owner:**

| | | |
|---|---|---|
| **9.** Entered into any agreement or arrangement providing for the future sale of the insurance certificate applied for in this application? | ❑ Yes | ❑ No |
| **10.** Entered into any agreement or arrangement where the Proposed Insured will receive financing or a loan, including forgivable loans, to pay some or all of the premiums, costs, or other expenses associated with this loan? | ❑ Yes | ❑ No |
| **11.** Entered into any agreement either orally or in writing by which you are to receive any form of consideration in exchange for procuring the insurance certificate you are applying for? | ❑ Yes | ❑ No |

*If you need more space, please use the additional information section on page 4.*

## SECTION 1 – Physician Information

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning the present health of the Proposed Insured.

❑ Check here if no doctor, practitioner, or health care facility is known.

Physician name _____ Phone number (  ) _____

Name of practice/clinic _____ Fax number (  ) _____

Street _____ City_____ State_____ ZIP _____

Date last consulted _____ Provide reasons for treatments and the results. _____

_____

List all currently prescribed medications, dosage, and frequency. _____

_____

## SECTION 2 – Medical Questions

**PLEASE NOTE:** If FULL PARAMEDICAL exam is required, completion of medical questions is OPTIONAL but will expedite your application.

**1. HEIGHT/WEIGHT** Height_____ Weight_____

Has the Proposed Insured experienced a change in weight (greater than 10 pounds) in the past 12 months? ❑ Yes ❑ No

If Yes, specify: Pounds lost_____ Pounds gained_____ Reason _____

**2.** Are the Proposed Insured's parents (P) or any siblings (S) deceased? ❑ Yes ❑ No If Yes, indicate below:

| Relationship to Proposed Insured | Age at death | State of health, specific conditions, cause of death |
|---|---|---|
| ❑ P ❑ S | | |
| ❑ P ❑ S | | |

**3.** Have the Proposed Insured's parents (P) or any siblings (S) ever had heart disease, diabetes, cancer, or mental illness? ❑ Yes ❑ No If Yes, indicate below:

| Relationship to Proposed Insured | State of health, specific conditions |
|---|---|
| ❑ P ❑ S | |
| ❑ P ❑ S | |

**4.** Is the Proposed Insured pregnant? ❑ Yes ❑ No Number of past pregnancies____ Any complications with the pregnancies? ❑ Yes ❑ No If Yes, indicate below:

| State of health and specific conditions |
|---|
| |

**5.** Has the Proposed Insured received counseling or treatment from any physician for, or been convicted for, the use of alcohol or the use and/or possession of drugs? ❑ Yes ❑ No

**6.** Has the Proposed Insured used amphetamines, barbiturates, cocaine, narcotics, marijuana, or other depressant, excitant, or hallucinatory drugs, unless administered on the advice of a physician? ❑ Yes ❑ No

*If you need more space, please use the additional information section below.*

## SECTION 2 – Medical Questions

**7.** During the past 10 years, has the Proposed Insured had, been diagnosed as having, been treated by a member of the medical profession for, or tested positive for:

| | | |
|---|---|---|
| **A.** | Heart attack; high blood pressure; stroke; or other disorder of the heart or blood vessels? | ❑ Yes ❑ No |
| **B.** | Cancer, tumor, cyst, mass; leukemia; lymph gland; thyroid; chronic fatigue; or any other blood abnormalities? | ❑ Yes ❑ No |
| **C.** | Diabetes or other endocrine disorder; sugar, albumin, or blood in urine; stone or other disorder of kidney, bladder, or prostate? | ❑ Yes ❑ No |
| **D.** | Lung or chronic respiratory disorder; asthma; bronchitis; emphysema; pneumonia; tuberculosis; or any other disorder of the respiratory system? | ❑ Yes ❑ No |
| **E.** | Intestinal bleeding; ulcer; hepatitis; or other disorder of stomach, liver, intestine, or gallbladder? | ❑ Yes ❑ No |
| **F.** | Any disease or disorder of the reproductive organs or breasts? | ❑ Yes ❑ No |
| **G.** | Brain, mental, or emotional nervous disorder; fainting; convulsions; paralysis; depression; anxiety; frequent recurring headaches; any other disease or disorder of the nervous system; attempted suicide; or ever been counseled for any of the above? | ❑ Yes ❑ No |
| **H.** | Arthritis; gout, loss of limb, or deformity; disorder of bone, joint, muscle, back, or spine; skin disorder; or any other disorder of the skeletal system? | ❑ Yes ❑ No |
| **I.** | Disease or disorder of eye, ears, nose, or throat? | ❑ Yes ❑ No |
| **J.** | Any diagnostic test, such as an electrocardiogram, x-ray, MRI, CT scan, biopsy, or blood study? | ❑ Yes ❑ No |
| **K.** | Any surgery? | ❑ Yes ❑ No |
| **L.** | Advised to have any diagnostic test, hospitalization, or surgery which has not been completed? | ❑ Yes ❑ No |
| **M.** | Treatment as an inpatient or outpatient or is currently confined in a hospital, institution, clinic, sanatorium, or other medical facility? | ❑ Yes ❑ No |

**8.** Has the Proposed Insured been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)? ❑ Yes ❑ No

**Details:** If you answered YES to any of the above questions, please provide details here.

| Question Number | Name of Physician Address if not already provided | Date/Duration of Illness | Diagnosis/Severity Medications/Treatments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Additional Information

**Use this page for any additional information. Attach a separate sheet if necessary.**

## Agreement/Acknowledgement

**Agreement/Disclosure**

**I have read this application for life insurance including any amendments and supplements and, to the best of my knowledge and belief, all statements are true and complete. I also agree that:**

- My statements in this application and any amendment(s), paramedical/medical exam, and supplement(s) are the basis of any certificate issued.
- This application and any amendment(s), paramedical/medical exam, and supplement(s) to this application will be attached to and, along with the articles of incorporation and bylaws of Royal Neighbors of America (Royal Neighbors), become part of the new certificate.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in this application and amendment(s), paramedical/medical exam, and any supplement(s).
- Only authorized officers of Royal Neighbors may: a) make or change any contract of insurance; b) make a binding promise about insurance; or c) change or waive any term of an application, receipt, or certificate.
- Corrections, additions, or changes to this application may be made by Royal Neighbors. Any such changes will be shown under "Corrections and Amendments." Acceptance of a certificate issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.
- Unless otherwise provided by the Conditional Receipt, Royal Neighbors will have no liability under this application unless and until: a) it has been received and approved by Royal Neighbors at its Home Office; b) the certificate has been issued and delivered to the certificateowner; c) the first premium has been paid to and accepted by Royal Neighbors; and d) at the time of delivery and payment, the facts concerning the insurability of the Insured are as stated in this application.
- If not a current member, I hereby apply to become a member of Royal Neighbors as indicated by my signature on page 6. As a member, I agree to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors of America was founded more than 100 years ago.

### Taxpayer Identification Number Certification

Under penalties of perjury, I, the Owner, certify that:
The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:
a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; **OR**
b) the IRS has notified me that I am not subject to backup withholding. *(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)*
I am a U.S. citizen or a U.S. resident alien for tax purposes.
**Please note:** The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

## Authorization

I, the Proposed Insured, hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical facility, insurance or reinsurance company, MIB, Inc., consumer reporting agency, division of motor vehicles, the veterans administration, or other government agency or department having information as to the diagnosis, treatment, or prognosis with respect to any physical or mental condition, or having any non-medical information, concerning me to release and disclose the entire medical record and any other protected health or other information concerning me within the past 10 years, without restriction, to Royal Neighbors of America, its agents, employees, representatives, or its reinsurers. I further authorize RNA, or its reinsurers, to make a brief report of my personal health information to MIB. This includes information on the treatment of alcohol, drug, and tobacco abuse, and psychiatric diagnosis and treatment. **In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, to give such information to any legal representative or agent employed by Royal Neighbors of America.**

I understand that the protected information is to be disclosed under this authorization so that Royal Neighbors of America may underwrite my application for life insurance, determine my eligibility for insurance, risk rating, or certificate issuance determinations, obtain reinsurance, administer claims and determine or fulfill responsibility for coverage and provision of benefits, administer coverage, and conduct other legally permissible activities that relate to any coverage I have applied for with Royal Neighbors of America. Any protected information obtained will not be released by Royal Neighbors of America or its reinsurers to any person or organization EXCEPT to other divisions and/or departments of Royal Neighbors of America or its reinsuring companies, MIB, other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted, or other persons or organizations performing business or legal services in connection with my application, insurance certificate(s), or claim for benefits or as may be otherwise lawfully required or as I may further authorize.

*(cont'd)*

I understand that this authorization shall remain in force for 24 months from the date signed if used in connection with an application for life insurance certificate, an application for reinstatement of a life insurance certificate, or a request for change in certificate benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a certificate.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative is entitled to receive a copy. I understand that this authorization may be revoked by me at any time in writing, and if I refuse to sign or if I subsequently revoke this authorization, Royal Neighbors of America may not be able to process this application, and if coverage has been issued, may not be able to process any benefit payments. I agree that Royal Neighbors of America shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation at its Home Office or to the extent that Royal Neighbors of America has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be re-disclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

❑ Check here if a copy of this authorization is desired.

Corrections and Amendments (For Home Office Use Only)

**SIGNATURES:**

Signed at city, state_____ Date_____

**Proposed Insured** _____

Signed at city, state_____ Date_____

**Proposed Owner** _____
(If other than Proposed Insured)
(If age 19 or over) If the Owner is a firm or corporation, include Officer's title with signature.

## Agent's Report

**REPLACEMENT:**

Do you have any knowledge or reason to believe that the Proposed Insured has in-force life insurance or annuity contracts that may be replaced as a result of this transaction? ❑ Yes ❑ No
If Yes, have you completed a replacement questionnaire and any other state required replacement forms? ❑ Yes ❑ No
Did you use only written sales material approved for use by Royal Neighbors? ❑ Yes ❑ No

Agent no._____ Agent license no._____ Agent chapter no. _____

Signature of Writing Agent_____ Date _____

Printed name of Writing Agent _____

A Fraternal Benefit Society

# Authorization for Pre-Authorized Collection Plan

I authorize Royal Neighbors of America and the financial institution named below to initiate automatic withdrawals from my checking/savings account. This authority will remain in effect until I notify Royal Neighbors of America or the bank to cancel it in such time as to afford a reasonable opportunity to act on the request. I can stop payment of any withdrawal by notifying Royal Neighbors of America three days before my scheduled withdrawal day. Royal Neighbors of America reserves the option to change the method of payment to another qualifying mode after the occurrence of a transaction not honored.

Name of financial institution_____ City_____ State _____

Name (please print)_____ Phone number (  )_____

Street address/PO Box _____

City _____ State_____ ZIP _____

I would like the payment withdrawn on the _____ (select from the 1st through the 28th) day of the month.

Checking account no. _____ OR Savings account no. _____

Signature as it appears
on bank records (do not print) X _____ Date _____

**PLEASE RETURN THIS AUTHORIZATION WITH A VOIDED CHECK OR A DEPOSIT SLIP**

## Important Information for Applicant

**Arizona:** On written request, Royal Neighbors of America will provide the certificateowner with information regarding the provisions of the life insurance certificate. If for any reason the certificateowner is not satisfied with the life insurance certificate, she/he may return the certificate to Royal Neighbors of America within 20 days (30 days if the certificateowner is 65 years of age or older), after receiving the certificate and receive a refund of all monies paid.

**Arkansas, California, New Mexico, Texas, Rhode Island, and West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurer for the purpose of defrauding or attempting to defraud the insurer. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurer or agent of an insurer who knowingly provides false, incomplete, or misleading facts or information to a certificateowner or claimant for the purpose of defrauding or attempting to defraud the certificateowner or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**District of Columbia and Georgia:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Indiana and Oklahoma:** Any person who knowingly, with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

**Kentucky and Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Jersey:** Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

**Ohio:** Any person who, with intent to defraud, or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oregon:** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**Tennessee, Washington, and Maine:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company (insurer) for the purpose of defrauding the insurer. Penalties include imprisonment, fines, and denial of insurance benefits.

**Royal Neighbors of America**
www.royalneighbors.org
Rock Island, Home Office
230 16th St., Rock Island, IL 61201
(800) 627-4762

A Fraternal Benefit Society

# Conditional Receipt

**Unless each and every condition specified in paragraph 1 below is fulfilled exactly, no insurance will become effective prior to delivery of the certificate of insurance. No agent of Royal Neighbors of America is authorized to alter or waive any of the conditions. Only checks or money orders are acceptable for payment when a conditional receipt is requested.**

Received from _____ on (Date)_____ the sum of $_____ in connection with an application to Royal Neighbors of America for the following insurance certificate:
Proposed Insured:_____ Life Insurance Amount: $_____ Plan: _____

1. All of the following conditions must be met before insurance may become effective prior to delivery of the certificate:
   (a) The payment indicated above must be at least equal to one month's premium at the premium class applied for. Assuming all other conditions under this paragraph have been met, if Royal Neighbors of America, in accordance with its rules, would have issued the certificate under a different premium class than applied for, and the premium paid was less than the premium that would have been required for the issuance of a certificate at this new premium class, then the death benefit payable under the receipt shall be such as the premium paid would have purchased at the new premium class.
   (b) All medical examinations and tests required by Royal Neighbors of America must be completed and received at the Home Office of Royal Neighbors of America.
   (c) As of the effective date, as defined below, the Proposed Insured must be a standard risk under rules and practices of Royal Neighbors of America for the plan and the amount of life insurance applied for, without change and at the rate of premium paid.
   (d) As of the effective date, the state of health and all factors affecting the insurance of the Proposed Insured must be as stated in the application.
2. When each and every one of the conditions of paragraph 1 have been met, the insurance coverage, as provided by the terms and conditions of the certificate of life insurance applied for, but for an amount not exceeding $400,000, will begin as of the Effective Date. "Effective Date" as used herein, means the later of:
   (a) the date of completion of the application; or
   (b) the date of completion of all medical examinations, electrocardiograms, x-rays, and other tests required by Royal Neighbors of America.
3. If the conditions have been met and coverage begins, coverage under this receipt will terminate 60 days from the date of this receipt unless prior to that date the insurance certificate is issued and accepted.

Signature of Agent Receiving the Payment_____

I understand and agree to the terms, conditions, and limits of this receipt and the agreements in the application, all of which have been fully explained to me by the agent.

Signature of Proposed Owner _____ Date _____

**NOTE: This receipt is to be issued only if the required payment is submitted with the application.**

## MIB, Inc., Notice

### This Notice is to be detached, read, and retained by the Proposed Insured

Information regarding your insurability will be treated as confidential. Royal Neighbors of America or its reinsurers make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or if a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at [(866) 692-6901, TTY (866) 346-3642]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Report Act. The address of MIB's information office is: MIB, [50 Braintree Hill Park, Suite 400, Braintree, MA 02184].

Royal Neighbors of America or its reinsurers may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

## Fair Credit Report Act Notice

This is to inform you that as part of our underwriting procedures in connection with this application, an investigative consumer report may be obtained on the Proposed Insured and the Proposed Owner. This report will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with neighbors, friends, and associates. You may request to be interviewed in connection with the preparation of the investigative consumer report. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. No information collected concerning the sexual orientation of the Proposed Insured or Proposed Owner will be used to determine her or his eligibility for life insurance.

# Royal Neighbors of America

# Application for Simplified Issue Individual Whole Life Insurance

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www.royalneighbors.org

Rock Island, Home Office
230 16th St., Rock Island, IL 61201
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101720 Rev. 10-2012

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# Application for Simplified Issue Individual Whole Life Insurance

❑ *Mail certificate to agent*

**PART 1**

## SECTION 1 – Proposed Insured

Name _____ Street _____

City _____ State _____ ZIP _____

SSN/Tax ID _____ Marital status ❑ S ❑ M ❑ W ❑ D Sex ❑ M ❑ F

Phone number ( ) _____ DOB _____ State/Country of birth _____

❑ U.S. driver's license ❑ Green Card ❑ Passport ID number _____ ID issuer _____

❑ Other _____ ID issue date _____ ID expiration date _____

E-mail address _____

Are you a U.S. citizen? ❑ Yes ❑ No If No, do you have a green card? ❑ Yes ❑ No Permanent Resident ID # _____

## SECTION 2 – Other Insurance

**1. EXISTING or APPLIED FOR INSURANCE**

Does the Proposed Insured have any existing life insurance *(L)* or annuity *(A)* contracts with this or any other company? ❑ Yes ❑ No

**IF YES,** complete and submit state replacement forms, if required, with this application. Provide details:

Company _____ ❑ Life Insurance ❑ Annuity Amount _____

**2. REPLACEMENT**

In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction *(except conversions)* involving an annuity or other life insurance? ❑ Yes ❑ No

**If Yes,** complete and submit a replacement questionnaire **AND** any other state required replacement forms with this application.

## SECTION 3 – Proposed Owner or Payor other than Owner (If Applicable)

**OWNER other than PROPOSED INSURED or ❑ PAYOR OTHER THAN OWNER (If applicable)å**

Name _____ SSN/Tax ID _____

Street _____ Phone number ( ) _____ DOB _____

City _____ State _____ ZIP _____ Relationship to Proposed Insured _____

❑ U.S. driver's license ❑ Green Card ❑ Passport E-mail address _____

❑ Other _____ Are you a U.S. citizen? ❑ Yes ❑ No

ID number _____ ID issuer _____ If No, do you have a green card? ❑ Yes ❑ No

ID issue date _____ ID expiration date _____ Permanent Resident ID # _____

❑ Check if you wish ownership to revert to Insured upon Owner's death.* * There may be tax consequences, please consult your tax advisor.

## SECTION 4 – Beneficiary(ies)

Multiple Beneficiaries will receive an equal percentage of proceeds unless otherwise instructed.

❑ **PRIMARY** (Percent of proceeds _____%)

Name _____

Street _____

City _____ State _____ ZIP _____

DOB _____ SSN/Tax ID _____

Relationship to Proposed Insured _____

❑ **PRIMARY** (Percent of proceeds _____%) ❑ **CONTINGENT**

Name _____

Street _____

City _____ State _____ ZIP _____

DOB _____ SSN/Tax ID _____

Relationship to Proposed Insured _____

## SECTION 5 – Information Regarding Insurance Applied for

**1. LIFE INSURANCE PLAN**

❑ Simplified Issue Whole Life ❑ Graded Death Benefit

**3. FACE AMOUNT $**_____

**2. RIDER**

❑ Accelerated Living Benefit Rider (no additional premium)

❑ Other _____

**4. AUTOMATIC PREMIUM LOAN will be provided.**

❑ No Check if APL is NOT desired.

*If you need more space, please attach the additional information on separate sheet.*

## SECTION 6 – Payment Information

If **Electronic Payment** is chosen, complete Pre-Authorized Collection (PAC) form on page 4.

**1. PAYMENT MODE** *(Check one)*

Direct bill: ❑ Annual ❑ Semi-Annual ❑ Quarterly

Electronic payment: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly ❑ Payment with app $_____

❑ Draft first payment Payment quoted $_____

**2. BILLING ADDRESS INFORMATION**

❑ Proposed Insured's address ❑ Primary Owner's address

**PART 2**

## SECTION 1 – Physician Information

Please provide name of doctor, practitioner, or health care facility who can provide the most complete and up-to-date information concerning the present health of the Proposed Insured. ❑ Check here if no doctor, practitioner, or health care facility is known.

Physician name/Clinic _____ City_____ State_____ ZIP _____

Date last consulted _____ Provide reasons for treatments and the results. _____

List all currently prescribed medications, dosage, frequency, and diagnosis. _____

_____

## SECTION 2 – Medical Questions

| | | |
|---|---|---|
| **1.** Has the Proposed Insured used tobacco in any form in the last 12 months? | ❑ Yes | ❑ No |
| ***If any answer to questions 2 through 7 is Yes, the Proposed Insured is not eligible for ANY coverage.*** | | |
| **2.** Is the Proposed Insured currently: | | |
| a. Hospitalized, in a nursing facility or receiving Hospice Care? | ❑ Yes | ❑ No |
| b. Confined to a wheelchair, bed, or using oxygen equipment to assist in breathing? | ❑ Yes | ❑ No |
| **3.** Has a member of the medical profession ever diagnosed or treated the Proposed Insured for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any immune deficiency disease; or has the Proposed Insured tested positive for the Human Immunodeficiency Virus (HIV)? | ❑ Yes | ❑ No |
| **4.** Has the Proposed Insured ever been diagnosed as having or been treated for: | | |
| a. Congestive heart failure, or had or been recommended to have an organ transplant? | ❑ Yes | ❑ No |
| b. Insulin shock, diabetic coma, amputation caused by disease, or taken insulin shots prior to age 50? | ❑ Yes | ❑ No |
| **5.** During the past 18 months has the Proposed Insured been diagnosed as having: | | |
| a. Stroke, aneurysm, cardiomyopathy, or circulatory surgery? | ❑ Yes | ❑ No |
| b. Angina (chest pain), heart attack or failure, or heart surgery? | ❑ Yes | ❑ No |
| **6.** During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for: | | |
| a. Internal Cancer, Melanoma, or Leukemia? | ❑ Yes | ❑ No |
| b. Dementia, Alzheimer's Disease, mental incapacity? | ❑ Yes | ❑ No |
| c. Cirrhosis, liver disease, kidney failure (including dialysis), chronic kidney disease, or systemic lupus? | ❑ Yes | ❑ No |
| **7.** During the past 18 months, has the Proposed Insured been diagnosed as having: | | |
| a. A condition expected to result in death within 12 months? | ❑ Yes | ❑ No |
| b. Been advised by a medical professional to have any diagnostic testing which has not been completed or for which the results have not been received? | ❑ Yes | ❑ No |
| c. Been recommended to have treatment or counseling for alcohol or drug abuse? | ❑ Yes | ❑ No |
| **8.** Prior to the age of 50 or during the past 36 months, has the Proposed Insured been diagnosed as having, or been hospitalized for: | | |
| a. Stroke, angina (chest pain), heart attack, or cardiomyopathy? | ❑ Yes | ❑ No |
| b. Heart or circulatory surgery (including pacemaker, heart valve replacement, by-pass, angioplasty, stent implant, or any procedure to improve circulation to the heart or brain)? | ❑ Yes | ❑ No |
| **9.** During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for: | | |
| a. Emphysema or chronic obstructive pulmonary disease (COPD)? | ❑ Yes | ❑ No |
| b. Neuromuscular disease (including Multiple Sclerosis, Lou Gehrig's Disease, Epilepsy, or Parkinson's Disease)? | ❑ Yes | ❑ No |

## Taxpayer Identification Number Certification

Under penalties of perjury, I, the Proposed Owner, certify that:

The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:

a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; **OR**

b) the IRS has notified me that I am not subject to backup withholding. *(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)*

I am a U.S. citizen or a U.S. resident alien for tax purposes. **Please note:** The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

## Agreement/Acknowledgement

**Agreement/Disclosure: I have read this application for life insurance including any amendments and supplements and, to the best of my knowledge and belief, all statements are true and complete. I also agree that:**

- My statements in this application and any amendment(s), paramedical/medical exam, and supplement(s) are the basis of any certificate issued and will be attached to and, along with the articles of incorporation and bylaws of Royal Neighbors of America (Royal Neighbors), become part of the new certificate.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in this application and amendment(s), paramedical/medical exam, and any supplement(s).
- Only authorized officers of Royal Neighbors may: a) make or change any contract of insurance; b) make a binding promise about insurance; or c) change or waive any term of an application, receipt, or certificate.
- Corrections, additions, or changes to this application may be made by Royal Neighbors. Any such changes will be shown under "Corrections and Amendments." Acceptance of a certificate issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.
- If not a current member, I, the Proposed Insured, hereby apply to become a member of Royal Neighbors as indicated by my signature on page 3. As a member, I agree to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors was founded more than 100 years ago.

## Authorization

I, the Proposed Insured, hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical facility, insurance or reinsurance company, MIB, Inc., consumer reporting agency, division of motor vehicles, the veterans administration, or other government agency or department having information as to the diagnosis, treatment, or prognosis with respect to any physical or mental condition, or having any non-medical information, concerning me to release and disclose the entire medical record and any other protected health or other information concerning me within the past 10 years, without restriction, to Royal Neighbors of America (Royal Neighbors), its agents, employees, or representatives. I further authorize RNA, or its reinsurers, to make a brief report of my personal health information to MIB. This includes information on the treatment of alcohol, drug, and tobacco abuse, and psychiatric diagnosis and treatment. **In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, to give such information to any legal representative or agent employed by Royal Neighbors.**

I understand that the protected information is to be disclosed under this authorization so that Royal Neighbors may underwrite my application for life insurance, determine my eligibility for insurance, risk rating, or certificate issuance determinations, administer claims and determine or fulfill responsibility for coverage and provision of benefits, administer coverage, and conduct other legally permissible activities that relate to any coverage I have applied for with Royal Neighbors. Any protected information obtained will not be released by Royal Neighbors to any person or organization EXCEPT to other divisions and/or departments of Royal Neighbors, MIB, other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted, or other persons or organizations performing business or legal services in connection with my application, insurance certificate(s), or claim for benefits or as may be otherwise lawfully required or as I may further authorize.

I understand that this authorization shall remain in force for 24 months from the date signed if used in connection with an application for life insurance certificate, an application for reinstatement of a life insurance certificate, or a request for change in certificate benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a certificate.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative is entitled to receive a copy. I understand that this authorization may be revoked by me at any time in writing, and if I refuse to sign or if I subsequently revoke this authorization, Royal Neighbors may not be able to process this application, and if coverage has been issued, may not be able to process any benefit payments. I agree that Royal Neighbors shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation at its Home Office or to the extent that Royal Neighbors has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be re-disclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

❑ Check here if a copy of this authorization is desired.

**Additional Information:**

Corrections and Amendments (For Home Office Use Only)

Except as may be provided under the Conditional Receipt on page 5 of this application, Royal Neighbors will have no liability under this application unless and until: a) it has been received and approved by Royal Neighbors at its Home Office; b) the certificate has been issued and delivered to the certificateowner; c) the first premium has been paid to and accepted by Royal Neighbors; and d) at the time of delivery and payment, the facts concerning the insurability of the Insured are as stated in this application.

**SIGNATURES:**

Signed at city, state_____ Date_____

**Proposed Insured** _____

Signed at city, state_____ Date_____

**Proposed Owner** _____

(If other than Proposed Insured) If the Owner is a firm or corporation, include Officer's title with signature.

## Agent's Report

**REPLACEMENT:**

Do you have any knowledge or reason to believe the Proposed Insured has any existing or applied for life insurance or annuity contracts with this or any other company? ❑ Yes ❑ No

If Yes, and applicable, have you completed a replacement questionnaire and any other state required replacement forms? ❑ Yes ❑ No

Do you have any knowledge or reason to believe that the Proposed Insured has in-force life insurance or annuity contracts that may be replaced as a result of this transaction? ❑ Yes ❑ No

If Yes, and applicable, have you completed a replacement questionnaire and any other state required replacement forms? ❑ Yes ❑ No

Did you use only written sales material approved for use by Royal Neighbors? ❑ Yes ❑ No

Did you personally review the I.D. of the Owner? ❑ Yes ❑ No If Yes, form of I.D. _____

Did you personally interview the Proposed Insured? ❑ Yes ❑ No Was the proposed insured with you at the time of the interview? ❑ Yes ❑ No

Agent no._____ Agent license no._____ Agent chapter no. _____

Signature of Writing Agent_____ Date _____

Printed name of Writing Agent _____

If applicable, complete and sign the following statement*(s)*:

Agent Signature_____ Date _____

Agent Name_____ ID Number _____ Percent _____
Please print

Agent Signature_____ Date _____

Agent Name_____ ID Number _____ Percent _____
Please print

ROYAL NEIGHBORS OF AMERICA®

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## Authorization for Pre-Authorized Collection Plan

I authorize Royal Neighbors of America *(Royal Neighbors)* and the financial institution named below to initiate automatic withdrawals from my checking/savings account. This authority will remain in effect until I notify Royal Neighbors or the bank to cancel it in such time as to afford a reasonable opportunity to act on the request. I can stop payment of any withdrawal by notifying Royal Neighbors three days before my scheduled withdrawal day. Royal Neighbors reserves the option to change the method of payment to another qualifying mode after the occurrence of a transaction not honored.

Name of financial institution_____ City_____ State _____

Name *(please print)*_____ Phone number ( ) _____

Street address/PO Box _____

City _____ State_____ ZIP _____

I would like the payment withdrawn on the _____ day of the month. *(If no day is selected the default day is the 5th of the month.)*

Routing no._____

Checking account no. _____ OR Savings account no. _____

Signature as it appears
on bank records X _____ Date_____

**PLEASE RETURN THIS AUTHORIZATION WITH A VOIDED CHECK**

*This receipt must be completed and given to every applicant for insurance.*

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# Conditional Receipt

**Unless each and every condition specified in paragraph 1 below is fulfilled exactly, no insurance will become effective prior to delivery of the certificate of insurance. No agent of Royal Neighbors of America *(Royal Neighbors)* is authorized to alter or waive any of the conditions.**

Received from _____ on *(Date)*_____ the sum of ❑ $_____ / ❑ no money received with application in connection with an application to Royal Neighbors for the following insurance certificate ("No money received" incudes all applications where the first premium is to be paid by preauthorized collection from payor's account. If this box is checked no insurance will be in effect until all conditions provided in the certificate of insurance and application have been fully complied with.):

Proposed Insured:_____ Life Insurance Amount: $_____ Plan: _____

1. All of the following conditions must be met before insurance may become effective prior to delivery of the certificate:
   a) The payment indicated above must be at least equal to one month's premium at the premium class applied for. Assuming all other conditions under this paragraph have been met, if Royal Neighbors, in accordance with its rules, would have issued the certificate under a different premium class than applied for, and the premium paid was less than the premium that would have been required for the issuance of a certificate at this new premium class, then the death benefit payable under the receipt shall be such as the premium paid would have purchased at the new premium class.
   b) All medical requirements required by Royal Neighbors must be completed and received at the Home Office of Royal Neighbors.
   c) As of the effective date, as defined below, the Proposed Insured must be a standard risk under rules and practices of Royal Neighbors for the plan and the amount of life insurance applied for, without change and at the rate of premium paid.
   d) As of the effective date, the state of health and all factors affecting the insurance of the Proposed Insured must be as stated in the application.
2. When each and every one of the conditions of paragraph 1 have been met, the insurance coverage, as provided by the terms and conditions of the certificate of life insurance applied for will begin as of the Effective Date. "Effective Date" as used herein, means the later of:
   a) the date of completion of the application; or
   b) the date of completion of all medical requirements required by Royal Neighbors.
3. If the conditions have been met and coverage begins, coverage under this receipt will terminate 60 days from the date of this receipt unless prior to that date the insurance certificate is issued and accepted.

**IMPORTANT INFORMATION: If no check or money order is received with this application, then this conditional insurance does not provide coverage and no insurance will be in effect until all conditions provided in the certificate of insurance and application have been fully complied with.**

Signature of Agent Receiving the Payment_____

Signature of Proposed Insured _____

**I understand and agree to the terms, conditions, and limits of this receipt and the agreements in the application, all of which have been fully explained to me by the agent.**

Signature of Proposed Owner_____

**Royal Neighbors of America**
www.royalneighbors.org
Rock Island, Home Office
230 16th St., Rock Island, IL 61201
(800) 627-4762

**This Page is to be detached, read, and retained by the Proposed Insured**

## Important Information for Applicant

**Arkansas and California:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
**District of Columbia:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
**New Jersey:** Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.
**Oregon:** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

## MIB, Inc., Notice

Information regarding your insurability will be treated as confidential. Royal Neighbors or its reinsurers may make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or if a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at [(866) 692-6901, TTY (866) 346-3642]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Report Act. The address of MIB's information office is: MIB, [50 Braintree Hill Park, Suite 400, Braintree, MA 02184].

Royal Neighbors or its reinsurers may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

## Fair Credit Report Act Notice

This is to inform you that as part of our underwriting procedures in connection with this application, an investigative consumer report may be obtained on the Proposed Insured and the Proposed Petitioner. This report will provide applicable information concerning character, general reputation, personal characteristics, and mode of living.* This information will be obtained through personal interviews with neighbors, friends, and associates. You may request to be interviewed in connection with the preparation of the investigative consumer report. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. No information collected concerning the sexual orientation of the Proposed Insured or Proposed Petitioner will be used to determine her or his eligibility for life insurance.
**Information obtained will not be used to determine sexual orientation.*

**Royal Neighbors of America**
www.royalneighbors.org

Rock Island, Home Office
230 16th St., Rock Island, IL 61201
(800) 627-4762

# Royal Neighbors of America

# Application for Single Premium Whole Life Insurance

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# Application for Single Premium Whole Life Insurance

**PART 1**

Mail Certificate to: ❑ Agent ❑ Owner

## SECTION 1 – Proposed Insured

Name _____ Street _____
City _____ State _____ ZIP _____
Phone number (_____) _____ Identification:
DOB _____ ❑ U.S. driver's license ❑ Government issued ID ❑ Passport
SSN/Tax ID _____ ❑ Green Card ID number _____
Marital status ❑ S ❑ M ❑ W ❑ D Sex ❑ M ❑ F ID issuer _____ ID expiration date _____
State/Country of birth _____ E-mail address _____
Are you a U.S. citizen? ❑ Yes ❑ No Length of citizenship _____ If No, are you a legal U.S. resident? ❑ Yes ❑ No

## SECTION 2 – Other Insurance

**1. EXISTING or APPLIED FOR INSURANCE**
Does the Proposed Insured have any existing life insurance *(L)* or annuity *(A)* contracts with this or any other company? ❑ Yes ❑ No
**IF YES,** complete and submit state replacement forms, if required, with this application.

**2. REPLACEMENT**
In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction *(except conversions),* involving an annuity or other life insurance? ❑ Yes ❑ No

**If Yes,** complete and submit a replacement questionnaire **AND** any other state required replacement forms with this application.

## SECTION 3 – Proposed Owner*

*** Complete if Owner is other than Proposed Insured**

**1. OWNER**
Name _____ Relationship to Proposed Insured _____
Street _____ E-mail address _____
City _____ State _____ ZIP _____ Identification:
SSN/Tax ID _____ ❑ U.S. driver's license ❑ Government issued ID ❑ Passport
Phone number (  ) _____ DOB _____ ❑ Green Card ID number _____
Are you a U.S. citizen? ❑ Yes ❑ No Length of citizenship _____ ID issuer _____ ID expiration date _____
If No, are you a legal U.S. resident? ❑ Yes ❑ No

## SECTION 4 – Beneficiary*(ies)*

Multiple Beneficiaries will receive an equal percentage of proceeds per capita unless otherwise instructed.

**❑ PRIMARY**
Name _____
Street _____
City _____ State _____ ZIP _____
DOB _____ SSN/Tax ID _____
Relationship to Proposed Insured _____
Percent of proceeds _____%

**❑ PRIMARY ❑ CONTINGENT**
Name _____
Street _____
City _____ State _____ ZIP _____
DOB _____ SSN/Tax ID _____
Relationship to Proposed Insured _____
Percent of proceeds _____%

## SECTION 5 – Information Regarding Insurance Applied for

**1. PRODUCT NAME** _____
❑ Single Premium Whole Life

**2. SINGLE PREMIUM –**
❑ Cash with application .....$ _____
❑ Cash to be received before issue .....$ _____
❑ Funds from §1035 Exchange .....$ _____
(from existing life contract only)

**3. ESTIMATED FACE AMOUNT** ..... **$** _____

**5. RIDERS**
❑ Accelerated Living Benefit Rider *(no additional premium)*

**4. DIVIDEND OPTION**
❑ Paid in cash
❑ Left on deposit to accumulate at interest

## SECTION 6 – Financial Questions

**Has the Proposed Insured or Owner:**

1. Entered into any agreement or arrangement providing for the future sale of the insurance certificate applied for in this application? ❑ Yes ❑ No
2. Entered into any agreement or arrangement where someone else will pay some or all of the premium, or the Proposed Insured or Owner will receive financing or a loan, including forgivable loans, to pay some or all of the premium, costs or other expenses associated with this loan? ❑ Yes ❑ No
3. Entered into any agreement either orally or in writing by which you are to receive any form of consideration in exchange for procuring the insurance certificate applied for? ❑ Yes ❑ No

**Financial Information:** (Please initial box if you do not want to disclose information)

Annual Gross Income .....$ _____ ☐

Liquid assets (e.g. checking account, savings account, CDs) .....$ _____ ☐

**Source of Funds to Pay Single Premium (e.g. savings):** _____

**Available Funds:**

Do you have sufficient cash or other liquid funds for living expenses and emergencies, such as unexpected medical expenses, in addition to the money you plan to use to purchase this life insurance. ❑ Yes ❑ No

# PART 2

## SECTION 1 – Proposed Insured Physician Information

Provide name and address of primary physician, practitioner, or health care facility who can provide the most complete and up-to-date information concerning the present health of the Proposed Insured:

Physician name _____ Name of practice/clinic _____

Street _____ City, State, ZIP _____

Phone number (  ) _____ Fax number (  ) _____

## SECTION 2 – Proposed Insured Medical Information

1. Height (ft. & in.) _____ Weight (lbs.) _____
2. In the past 12 months has the Proposed Insured used tobacco in any form? ❑ Yes ❑ No
3. In the past 12 months has the Proposed Insured:
   a. had any diagnostic testing recommended by a medical professional which has not been completed or for which the results have not been received? ❑ Yes ❑ No
   b. been confined to a wheelchair, used oxygen to assist breathing, or hospitalized or in a long term care facility? ❑ Yes ❑ No
4. Within the past 5-years has a member of the medical profession diagnosed the Proposed Insured as having, treated, or advised to seek treatment for, or prescribed medication for:
   a. cancer, diabetes, stroke or any disease or disorder of the heart, circulatory, respiratory, kidney, liver, brain or nervous system? ❑ Yes ❑ No
   b. Alzheimer's disease, dementia or other forms of mental disorder or incapacity? ❑ Yes ❑ No
5. Within the past 5-years has the Proposed Insured:
   a. used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician? ❑ Yes ❑ No
   b. received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? ❑ Yes ❑ No
6. Has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ❑ Yes ❑ No

**For questions 3 through 6, please circle the applicable item(s) in each question above and provide details to all YES answers below.**

| Ques. No. | Specify condition | Date | Treatment/Results | Physician/Hospital/Address |
|---|---|---|---|---|
| | | | | |

## Taxpayer Identification Number Certification

Under penalties of perjury, I, the Proposed Owner, certify that:
The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:
a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; **OR**
b) the IRS has notified me that I am not subject to backup withholding. *(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)*
I am a U.S. citizen or a U.S. resident alien for tax purposes. **Please note:** The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

## Agreement/Acknowledgement

**Agreement/Disclosure: I have read this application for life insurance including any amendments and supplements and, to the best of my knowledge and belief, all statements are true and complete. I also agree that:**

- My statements in this application and any amendment(s), paramedical/medical exam, and supplement(s) are the basis of any certificate issued and will be attached to and, along with the articles of incorporation and bylaws of Royal Neighbors of America (Royal Neighbors), become part of the new certificate.
- No information will be deemed to have been given to Royal Neighbors unless it is stated in this application and amendment(s), paramedical/medical exam, and any supplement(s).
- Only authorized officers of Royal Neighbors may: a) make or change any contract of insurance; b) make a binding promise about insurance; or c) change or waive any term of an application, receipt, or certificate.
- Corrections, additions, or changes to this application may be made by Royal Neighbors. Any such changes will be shown under "Corrections and Amendments." Acceptance of a certificate issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.
- If not a current member, I, the Proposed Insured, hereby apply to become a member of Royal Neighbors as indicated by my signature on page 4. As a member, I agree to uphold the principles of Faith, Unselfishness, Courage, Endurance, and Humility upon which Royal Neighbors was founded more than 100 years ago.
- **The type of insurance product I am purchasing has characteristics which generally require treatment as a Modified Endowment contract (MEC). I have received information regarding MEC's and understand that if the transaction now pending with respect to my life insurance certificate becomes a MEC, it may result in future tax liability for me.**

## Authorization

I, the Proposed Insured, hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, or other medical facility, insurance or reinsurance company, MIB, Inc., consumer reporting agency, division of motor vehicles, the veterans administration, or other government agency or department having information as to the diagnosis, treatment, or prognosis with respect to any physical or mental condition, or having any non-medical information, concerning me to release and disclose the entire medical record and any other protected health or other information concerning me within the past 10 years, without restriction, to Royal Neighbors of America (Royal Neighbors), its agents, employees, or representatives. I further authorize RNA, or its reinsurers, to make a brief report of my personal health information to MIB. This includes information on the treatment of alcohol, drug, and tobacco abuse, and psychiatric diagnosis and treatment. **In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, to give such information to any legal representative or agent employed by Royal Neighbors.**

I understand that the protected information is to be disclosed under this authorization so that Royal Neighbors may underwrite my application for life insurance, determine my eligibility for insurance, risk rating, or certificate issuance determinations, administer claims and determine or fulfill responsibility for coverage and provision of benefits, administer coverage, and conduct other legally permissible activities that relate to any coverage I have applied for with Royal Neighbors. Any protected information obtained will not be released by Royal Neighbors to any person or organization EXCEPT to other divisions and/or departments of Royal Neighbors, MIB, other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted, or other persons or organizations performing business or legal services in connection with my application, insurance certificate(s), or claim for benefits or as may be otherwise lawfully required or as I may further authorize.

I understand that this authorization shall remain in force for 24 months from the date signed if used in connection with an application for life insurance certificate, an application for reinstatement of a life insurance certificate, or a request for change in certificate benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a certificate.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative is entitled to receive a copy. I understand that this authorization may be revoked by me at any time in writing, and if I refuse to sign or if I subsequently revoke this authorization, Royal Neighbors may not be able to process this application, and if coverage has been issued, may not be able to process any benefit payments. I agree that Royal Neighbors shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation at its Home Office or to the extent that Royal Neighbors has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be re-disclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

**Additional Information:**

Corrections and Amendments (For Home Office Use Only)

**FRAUD NOTICE/WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

## Signatures

Except as may be provided under the Conditional Receipt on page 5 of this application, Royal Neighbors will have no liability under this application unless and until: a) it has been received and approved by Royal Neighbors at its Home Office; b) the certificate has been issued and delivered to the certificateowner; c) the first premium has been paid to and accepted by Royal Neighbors; and d) at the time of delivery and payment, the facts concerning the insurability of the Insured are as stated in this application.

**SIGNATURES:**

Signed at city, state_____ Date_____

**Proposed Insured** _____

Signed at city, state_____ Date_____

**Proposed Owner** _____
(If other than Proposed Insured)

## Agent's Report

**REPLACEMENT:**

Do you have any knowledge or reason to believe the Proposed Insured has any existing or applied for life insurance or annuity contracts with this or any other company? ❑ Yes ❑ No

If Yes, and applicable, have you completed a replacement questionnaire and any other state required replacement forms? ❑ Yes ❑ No

Do you have any knowledge or reason to believe that the Proposed Insured has in-force life insurance or annuity contracts that may be replaced as a result of this transaction? ❑ Yes ❑ No

If Yes, and applicable, have you completed a replacement questionnaire and any other state required replacement forms? ❑ Yes ❑ No

Did you use only written sales material approved for use by Royal Neighbors? ❑ Yes ❑ No

Did you personally review a photo I.D. of the Proposed Insured and Owner? ❑ Yes ❑ No If Yes, form of I.D. _____

Was interview completed at point-of-sale? ❑ Yes ❑ No

Agent no._____ Agent license no._____ Agent chapter no. _____

Signature of Writing Agent_____ Date _____

Printed name of Writing Agent _____

If applicable, complete and sign the following statement*(s)*:

Agent Signature_____ Date _____

Agent Name _____ ID Number _____ Percent _____
Please print

Agent Signature_____ Date _____

Agent Name _____ ID Number _____ Percent _____
Please print

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Royal Neighbors of America
230 16th Street
Rock Island, IL 61201
Toll-free (800) 627-4762

A Fraternal Benefit Society

# Conditional Receipt

**Unless each and every condition specified below is fulfilled exactly, no insurance will become effective prior to delivery of the certificate of insurance. No agent of Royal Neighbors of America *(Royal Neighbors)* is authorized to alter or waive any of the conditions.**

Received from _____ on *(Date)*_____ the sum of ❑ $_____ (in the form of a check or cashier's check only) / ❑ no money received with application in connection with an application to Royal Neighbors for the following insurance certificate:
Proposed Insured:_____ Life Insurance Amount: $_____ Plan: _____

1. All of the following conditions must be met before insurance may become effective prior to delivery of the certificate:
   a) The payment indicated above must be at least equal to the greater of $10,000 or the single premium necessary to pay the premium for the face amount applied for at the standard rate class. Assuming all the other conditions under this paragraph have been met, if Royal Neighbors, in accordance with its rules, would have issued the certificate for a lesser amount than applied for, and the premium paid was at least equal to the premium that would have been required for the issuance of a certificate at this new face amount, then the death benefit payable under the receipt shall be such as the premium paid would have purchased.
   b) All medical examinations, records, and tests required by Royal Neighbors must be completed and received at the Home Office of Royal Neighbors.
   c) As of the effective date, as defined below, the Proposed Insured must be a standard risk under rules and practices of Royal Neighbors for the plan and the amount of life insurance applied for, without change and at the rate of premium paid.
   d) As of the effective date, the state of health and all factors affecting the insurance of the Proposed Insured must be as stated in the application.
2. When each and every one of the conditions of paragraph 1 have been met, the insurance coverage, as provided by the terms and conditions of the certificate of life insurance applied for, but not greater than $400,000, will begin as of the Effective Date. "Effective Date" as used herein, means the later of:
   a) the date of completion of the underwriting decision; or
   b) the receipt in the Home Office of all funds from the proposed owner or through an IRS Section 1035 Exchange sufficient to meet the requirements for insurance coverage under paragraph 1.
3. If the conditions have been met and coverage begins, coverage under this receipt will terminate 60 days from the date of this receipt unless prior to that date the insurance certificate is issued, delivered, and accepted.

**IMPORTANT INFORMATION: If no check or money order is received with this application or funds from an IRS Section 1035 Exchange have not been received at the Home Office, then this conditional insurance is not effective and there will be no insurance in effect unless and until a certificate for the insurance applied for has been issued and delivered and the full amount of the premium due has been received at the Home Office of Royal Neighbors.**

Signature of Agent Receiving the Payment_____

Signature of Proposed Insured _____

**I understand and agree to the terms, conditions, and limits of this receipt and the agreements in the application, all of which have been fully explained to me by the agent.**

Signature of Proposed Owner _____

**This Page is to be detached, read, and retained by the Proposed Insured**

## MIB, Inc., Notice

Information regarding your insurability will be treated as confidential. Royal Neighbors or its reinsurers may make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or if a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at [(866) 692-6901, TTY (866) 346-3642]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Report Act. The address of MIB's information office is: MIB, [50 Braintree Hill Park, Suite 400, Braintree, MA 02184].

Royal Neighbors or its reinsurers may also release information in its file to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

## Fair Credit Report Act Notice

This is to inform you that as part of our underwriting procedures in connection with this application, an investigative consumer report may be obtained on the Proposed Insured and the Proposed Owner. This report will provide applicable information concerning character, general reputation, personal characteristics, and mode of living.* This information will be obtained through personal interviews with neighbors, friends, and associates. You may request to be interviewed in connection with the preparation of the investigative consumer report. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. No information collected concerning the sexual orientation of the Proposed Insured or Proposed Owner will be used to determine her or his eligibility for life insurance.
**Information obtained will not be used to determine sexual orientation.*

## Notice of Potential Modified Endowment Contract

Section 7702A of the Internal Revenue Code places a limit on the amount and timing of premium payments for a life insurance contract. If the limit is exceeded, the contract becomes a Modified Endowment Contract (MEC).

Death benefits under a MEC are income tax free to the beneficiary. Any other value received from a MEC is referred to as a "distribution" and may result in an income tax liability. Distributions include cash withdrawals; cash surrender of the contract, loans, and assignment of the contract to another person or institution.

Distributions are first considered to be any gain under the contract and the gain is taxable in the year that it is received. In addition, a taxable distribution is subject to a 10% tax penalty if the taxpayer has not attained age 59 ½, subject to certain exceptions contained in the tax code. Also, distributions received in the two year period prior to the date the contract becomes a MEC may be taxable.

Distributions that exceed the gain under the contract are not taxable.

Tax laws are subject to change.

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**Royal Neighbors of America**
www.royalneighbors.org
Rock Island, Home Office
230 16th St., Rock Island, IL 61201
(800) 627-4762

| | | | |
|---|---|---|---|
| ***SERFF Tracking #:*** | *RNOA-128727993* | ***State Tracking #:*** | ***Company Tracking #:*** *1725 RNOA-128727993* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Royal Neighbors of America* |
| ***TOI/Sub-TOI:*** | *L08 Life - Other/L08.000 Life - Other* | | |
| ***Product Name:*** | *Applications* | | |
| ***Project Name/Number:*** | *1725/1725* | | |

## Supporting Document Schedules

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Satisfied - Item: | Flesch Certification | | |
| Comments: | | | |
| Attachment(s): | | | |
| AR Certification of Flesch.pdf | | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Satisfied - Item: | Applications replaced: | | |
| Comments: | 1725 Rev. 8-2007<br>RNOA-125278342<br>10/30/2007<br><br>101720 Rev. 5-2010<br>RNOA-126647307<br>6/1/2010<br><br>111722-AR Rev. 8-2011<br>RNOA-127355351<br>9/1/2011 | | |

230 16th Street | Rock Island, IL 61201

Phone: (309) 788-4561 | Toll-free: (800) 627-4762
E-mail: contact@royalneighbors.org | Web site: www.royalneighbors.org

# CERTIFICATION OF FLESCH READING EASE SCORE

Royal Neighbors of America does hereby certify that the following certificate forms and application, specimen copies of which are submitted herewith, are in its judgment readable based on the factors specified in Arkansas Flesch Methodology Regulations.

| FORM | TITLE | FLESCH SCALE READABILITY ANALYSIS AND TEST SCORE |
|---|---|---|
| 11725 Rev. 10-2012 | Application for Term Life Insurance | 48.1 |
| 101720 Rev. 10-2012 | Application for Simplified Issue Individual Whole Life Insurance | 53.4 |
| 101722-AR Rev. 10-2012 | Application for Single Premium Whole Life Insurance | 52.2 |

- A Flesch reading ease test scores of the above forms is as indicated above.
- The forms are printed, except for specification pages, schedules and tables, in not less than ten point, one point leaded.
- The forms listed above were analyzed in their entirety both to the method and formula as specified in Arkansas Flesch Methodology Regulations.

Dated this 15th day of October 2012.

BY _____
Philip K. Blankenfeld – Compliance Manager